Approved, SCAO

Original - Court
1st copy - Friend of the Court
2nd copy - Plaintiff

3rd copy - Defendant
4th copy - Return

STATE OF MICHIGAN JUDICIAL CIRCUIT COUNTY	NOTICE OF NONCOMPLIANCE (HEALTH CARE COVERAGE)	CASE NO.

Friend of the Court address **FAX no.** **Telephone no.**

Plaintiff name, address, and telephone no.

Defendant name, address, and telephone no.

1. Date of mailing: _____
2. The Office of the Friend of the Court has reviewed your files and determined that you, as ☐ plaintiff, ☐ defendant, have failed to obtain or maintain dependant health care coverage available at a reasonable cost as ordered by the court.
3. **Within 21 days after this notice is mailed, you must complete either the "Proof of Health Care Coverage" or the "Request for Hearing" below and send it to the friend of the court.**
4. If you do not respond as required, the friend of the court office will notify your employer to deduct premiums for dependent health care coverage and will notify the insurer or plan administrator to enroll the child in dependent health coverage.
5. The order for dependent health care coverage will be applied to current and subsequent employers and periods of employment.

☐ Check this box if you have proof of health care coverage. Then: 1) complete this proof; and 2) photocopy your insurance card(s) and attach them to this proof. Return this proof and any attachments to the friend of the court.

PROOF OF HEALTH CARE COVERAGE

Medical insurance company name and address	Group/Policy/Contract number	Beginning date, if known	Name of policy holder
Dental insurance company name and address	Group/Policy/Contract number	Beginning date, if known	Name of policy holder
Optical insurance company name and address	Group/Policy/Contract number	Beginning date, if known	Name of policy holder

Individuals currently covered by your insurance

Name	Birthdate	Relationship	Medical (check)	Dental (check)	Optical (check)

Date _____ Signature _____

☐ Check this box if you want to request a hearing. Then date and sign the request and return it to the friend of the court.

REQUEST FOR HEARING

I request a hearing to show that health care coverage is not available at a reasonable cost.

Date _____ Signature _____